APPLICATION FOR RENEWAL OF: **MARYLAND STATE BOARD OF PHARMACY**

PLEASE MAKE CHECK PAYABLE TO: THE MARYLAND BOARD OF PHARMACY

FAILURE TO RENEW LICENSE BY _____ could result in additional fees due and/or action against your license.

CONTINUING EDUCATION REQUIREMENTS: You are required by law to participate in approved Continuing Education Programs before your Renewal License can be issued.

The required number of hours: _____

Return this Renewal Application & Fee by: _____ No License will be issued before: _____

RENEWAL FEE: $_____ Health Care Access and Cost Commission FEE $_____ **TOTAL FEE DUE: $_____**

LICENSE # ☐☐☐☐☐

FOR BOARD USE ONLY
STATUS BOX

1. Date Appl. Rec. _____
2. Amount Rec. _____
2a. Amount Owed _____
3. Date Updated _____
4. Date Printed _____
5. Date Mailed _____
Application Pending _____
   a. Awaiting CE Form
   b. Awaiting Signature
   c. Awaiting Fee
   d. Awaiting Disciplinary Issues
   e. Awaiting Board Approval
6. Date Returned to Applicant _____
7. Date Rec. Back to BD. _____

THIS IS YOUR ONLY NOTICE. AFTER _____ THE FEE IS $_____ ($_____ RENEWAL + $65 LATE FEE + $_____ HCACC FEE)

COMPLETE ONLY IF NAME HAS CHANGED. PLEASE PRINT.

LAST NAME AND GENERATIONAL INDICATOR (Jr., III, etc.)

FIRST NAME AND MIDDLE NAME/INITIAL

Complete only if address has changed. Please print.

ADDRESS

CITY STATE ZIP CODE

1. Social Security Number ☐☐☐ - ☐☐ - ☐☐☐☐

2. Date of Birth Month ☐☐ - Day ☐☐ - Year ☐☐

3. Race ☐
   1. Caucasian
   2. African American
   3. American Indian
   4. Oriental/Asian
   5. Hispanic
   6. Other

4. Sex ☐
   1. Male
   2. Female

4. Primary Location of Practice?

Zip Code ☐☐☐☐☐ County ☐☐

01 Allegany
02 Anne Arundel
03 Baltimore City
04 Calvert
05 Caroline
06 Carroll
07 Cecil
08 Charles
09 Dorchester
10 Frederick
11 Garrett
12 Harford
13 Howard
14 Kent
15 Montgomery
16 Prince George's
17 Queen Anne's
18 St. Mary's
19 Somerset
20 Talbot
21 Washington
22 Wicomico
23 Worcester
24 Baltimore County
25 District of Columbia
26 Other

6. Residence?

Zip Code ☐☐☐☐☐ County ☐☐

01 Allegany
02 Anne Arundel
03 Baltimore City
04 Calvert
05 Caroline
06 Carroll
07 Cecil
08 Charles
09 Dorchester
10 Frederick
11 Garrett
12 Harford
13 Howard
14 Kent
15 Montgomery
16 Prince George's
17 Queen Anne's
18 St. Mary's
19 Somerset
20 Talbot
21 Washington
22 Wicomico
23 Worcester
24 Baltimore County
25 District of Columbia
26 Other

5. Places of Employment?

a ☐☐ b ☐☐ c. ☐☐

01 Hospital
02 Nursing Home
03 Funeral Establishment
04 Clinic
05 Group Plan/HMO
06 Practitioner's Office-Self
07 Practitioner's Office-Partnership
08 Practitioner's Office-Employee
09 Physician's Office-Employee
10 Rehabilitation Agency/Clinic
11 Home Health
12 Visiting Nurse
13 Manufacturer/Industry
14 Retail Establishment
15 Wholesale Establishment
16 School System
17 University or College-Administration
18 University or College-Teaching
19 University or College-Clinical Practice
20 University or College-Research
21 Federal Gov't-Nonmilitary
22 Federal Gov't-Military
23 Other (employment in field of License)
24 Other (outside field of License)

7. Employment Status ☐
   1. Full-time (35 Hrs. or More)
   2. Part-time (35 Hrs. or Less)
   3. Unemployed
   4. Retired
   5. Other _____

8. Primary Employer ☐
   01. Private Sector - Profit
   02. Private Sector - Non Profit
   03. Federal Gov't - Military
   04. Federal Gov't - Non Military
   05. State Gov't
   06. Local Gov't
   07. Self Employed
   08. Other _____

10. Business Tel. No. ☐☐☐-☐☐☐-☐☐☐☐

Business Fax ☐☐☐-☐☐☐-☐☐☐☐

11. Business Name & Address _____

_____

_____

12. Business Permit # ☐☐☐☐☐☐

13. No. of years active in your profession? ☐☐

14. Last year of active practice? ☐☐

15. Previous Residence Since Last Renewal

1. Maryland 2. Out of State ☐

16. Maryland in State Graduate ☐

1. Yes 2. No

17. Year of Graduation ☐☐

18. Other States or Jurisdictions Licensed as a Pharmacist?

a. ☐☐ b. ☐☐

c. ☐☐ d. ☐☐

19. Licensed in another Profession? ☐

1. Yes 2. No

If yes, indicate the profession

_____

THIS SECTION MUST BE COMPLETED FOR YOUR RENEWAL TO BE ISSUED

I hereby certify that I have earned the 30 hours of Continuing Education, as required by the Maryland Board of Pharmacy.

Date: _____ Signature: _____

SINCE YOUR LAST REGISTRATION: FOR THE FOLLOWING, CHECK THE BOX YES, OR NO NEXT TO EACH QUESTION.

YES	NO		
☐	☐	1.	Have you been addicted to the use of drugs or alcohol with the result that your ability to practice your profession has been impaired? (You may respond no if you are currently in compliance with a contract with the pharmacist rehabilitation committee recognized by the Board.)
☐	☐	2. (a)	Has any State Licensing or Disciplinary Board, or a comparable body in the Armed Services denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, or revocation?
☐	☐	(b)	Have you surrendered or failed to renew a license in any State?
☐	☐	3.	Are there any outstanding complaints, investigations or charges pending against you in any State by any Licensing or Disciplinary Board for a comparable body in the Armed Services?
☐	☐	4.	Have you had a physical or mental illness that currently impairs your ability to practice your profession?
☐	☐	5.	Have you pled guilty, nolo contendre, or been convicted of, or received probation before judgment of any criminal act (excluding traffic violations)?
☐	☐	6.	Have you pled guilty, nolo contendre, or been convicted of, or received probation before judgment of driving while intoxicated or of a controlled dangerous substance offense?
☐	☐	7.	Has any hospital or related healthcare institution or employer denied you privileges or employment, denied any application for privileges or employment, failed to renew your privileges or contract or limited, restricted, suspended, revoked, or terminated your privileges or contract for any reason related to your practice?
☐	☐	8.	Have the conditions of your employment been affected by any termination of employment, suspension, or probation for any reason related to your practice?
☐	☐	9.	Has a malpractice suit been filed against you or has a claim for damages been settled or awarded against you?

ATTACH A DETAILED EXPLANATION FOR EACH QUESTION CIRCLED YES.

I affirm that the information I have given in answer to these question is true and correct to the best of my knowledge and belief.

Date: _____ Signature: _____

CONTINUING EDUCATION RECORD

You must complete and sign this form as required for your license to be renewed.

Name: _____ License Number: _____

Date: _____ Telephone Number (home) _____

PROGRAM	PROVIDER	DATE HOURS EARNED	ACPE/BD APPROVED NUMBER	# OF HOURS
			TOTAL	

I affirm, under penalty of perjury, that the information I have given on this record is true and correct to the best of my knowledge and belief.

_____ _____

SIGNATURE DATE

Use this date the continuing education hours were granted as indicated on certificate. Continuing Education credits must be obtained during the renewal period. The authorizing signature and date on the certificate, or some other verification of the date the credits were earned is required to be within the renewal period. You may copy this form if additional space is needed.

CONT

Name: _____ License Number: _____

Date: _____ Telephone Number (home) _____

PROGRAM	PROVIDER	DATE HOURS EARNED	ACPE/BD APPROVED NUMBER	# OF HOURS
			TOTAL	

I affirm, under penalty of perjury, that the information I have given on this record is true and correct to the best of my knowledge and belief.

_____ _____

SIGNATURE DATE

CONT

REPORT YOUR MAILING ADDRESS AND EMPLOYMENT LOCATION:

Regulation 10.34.06 - Reporting Pharmacist's Mailing Address and Location of Employment, was promulgated February 9, 1990. This requires each pharmacist to report the pharmacist's current mailing address on the license renewal application and to report any changes within thirty (30) days.

The place of employment should be reported on the license renewal application. If employed at more than one location, choose a primary location to report. Regulation requires a pharmacist to report the place of employment and notify the Board in writing within thirty (30) days of a change in primary employment.

☞ **PLEASE NOTE:** A licensee's business address is public information. If the business address is not available, the licensee's home address is public information per State Government Article, Section 10-617(h)(2)(ii).

IMPORTANT REMINDERS:

1. In order to have your license expire on your date of birth, please fill in (#2 front).
2. If you are employed at a Pharmacy, Manufacturer or Distributor located in the State of Maryland, provide the Permit Number. (#12 back)
3. **SIGN** CE Certification (center, back) of the renewal application and return the completed Continuing Education Record Sheet, unless this is your first renewal.
4. Answer the disciplinary questions [1-9]. Attach a **detailed** explanation for each question checked _ "Yes".
5. **SIGN** the bottom of the renewal form on the back.
6. Complete and **Sign** the Continuing Education Record.
7. Enclose a check or money order for $129.00.

☞ **If the renewal application is incomplete , the Board will return your application which will delay the processing of your application.**

LATE RENEWALS:

If your completed application with a check is not postmarked by **the end of your birth month** your pharmacist license will expire.

A renewal application received after the pharmacist license has expired will be assessed a $65.00 reinstatement fee.

If you submit a late renewal, please include the following:

- Renewal Fee; - $95.00
- MHCC Fee; - $34.00
- Reinstatement Fee; - $65.00
- Continuing Education Documentation; and
- Completed Application